MONTANA BOARD OF MEDICAL EXAMINERS
(301 South Park Avenue 4th Floor – Delivery Only)
PO Box 200513
Helena, MT 59620-0513
PHONE: 406-841-2361 or (406) 841-2364 FAX: 406-841-2305
E-MAIL: dlibsdmed@mt.gov **WEBSITE:** www.medicalboard.mt.gov

ILLEGIBLE AND INCOMPLETE APPLICATIONS WILL BE RETURNED.
(Please allow 10 days for processing from the date that the Board has a complete routine application)

LICENSING REQUIREMENTS FOR LICENSED NUTRITIONIST:

- Must be currently registered with the Commission on Dietetic Registration (CDR).
- Must have graduated from an accredited college or university in the field of dietetics, food and nutrition or public health.

FEES:

- **$58.50 – Nutritionist Application Fee** *Make payable to Montana Board of Medical Examiners*

DOCUMENTS:

- **Official Nutrition Education Transcripts**
- **Current Copy of CDR Card**
- **Recent National Practitioner Data Bank (NPDB) self-query (Letter Unopened)**
- **Current verification from all State Licensing Boards**

ADDITIONAL FORMS TO BE SUBMITTED FOR AN APPLICATION TO BE COMPLETE:

- **National Practitioner Data Bank (NPDB) self-query:** This form must be mailed directly to the address indicated in the instructions. The results will come to you; upon receipt please forward them to the Board office. This form can be obtained by calling NPDB at 800-767-6732 or visit www.npdb-hipdb.com on the Internet.
- **State Licensing Verification form:** This form must be sent to all state boards in which you hold or ever held a professional license. The completed verification must be returned directly to the Montana State Board of Medical Examiners.

APPLICATION PROCEDURES:

- A verification of licensure or letter of good standing must be sent directly from each state board in which the applicant is currently or has ever been licensed. Please make copies of the attached verification request form as needed. Some states charge a fee for verification. Contact each board prior to sending the request.
- Transcripts, which detail the course-by-course curriculum in schools and the completion of which directly entitled the applicant to corresponding diploma, must be sent **directly** to the Board of Medical Examiners by the institution only, not by the applicant.
- If the application is considered a non-routine application, there may be a delay in processing of the application. You may be requested to provide additional information, or make a personal appearance before the Board during a regularly scheduled Board meeting and/or the application may require Board consideration. Non-routine applications may take 120 days to process.

PROCESSING PROCEDURES:

- An application file must be complete before consideration of licensure. The applicant will be notified in writing of any items missing from the application file.
- An application takes 10 days to process from the time it is complete.
- Please be sure that the two nutritionist's references and the reference you list on your application complete the reference questionnaire and return the form directly to the Board office as soon as possible in order to complete your application.

For information with regard to the processing of this application and other concerns please contact the Board of Medical Examiners staff at (406) 841-2361 or (406) 841-2364 or email us at dlibsdmed@mt.gov

PLEASE BE SURE TO REVIEW THE MONTANA LAWS AND RULES FOR NUTRITIONISTS ON OUR WEBSITE:
www.medicalboard.mt.gov

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Application for Licensure as:

☐ **Nutritionist**

PLEASE TYPE OR PRINT IN INK.

(Please allow 10 days for processing from the date that the Board has a complete routine application)

1. FULL NAME: _____
   Last First Middle

2. OTHER NAME(S) KNOWN BY _____

3. BUSINESS NAME _____

4. BUSINESS ADDRESS _____
   Street or PO Box # City and State Zip

5. HOME ADDRESS _____
   Street or PO Box # City and State Zip

   PREFERRED MAILING ADDRESS ☐ Business ☐ Home E-MAIL ADDRESS _____

6. TELEPHONE (____) _____ (____) _____ (____) _____
   Business Home Fax

7. SOCIAL SECURITY NUMBER _____ FOREIGN ID NUMBER _____

8. DATE OF BIRTH _____ PLACE OF BIRTH _____ ☐ MALE ☐ FEMALE
   City/State

9. LICENSE NAME _____
   (State your name as it should appear on the license if granted.)

10. Please list all Post-High School education in the profession for which you are seeking licensure. Use supplemental sheet if needed.

Name of School	Address of School	Dates Attended	Degree Earned

11. Have you ever previously applied for a license to practice in Montana? If yes, give date and results. ☐ Yes ☐ No

12. Have you ever been denied licensure or the opportunity to take a professional licensing examination in any state or country? If yes, attach a detailed explanation. ☐ Yes ☐ No

13. Have you ever withdrawn an application for a nutritionist license? If yes, please give the state and reason for withdrawal. ☐ Yes ☐ No

14. **PRACTICE HISTORY:** List all activities after professional school in chronological order, up to and including the present. Specify nature of activity; for example, private practice, hospital practice, vacation, school, private employment, etc. Account for all periods of time longer than 1 month. Indicate specific month and year for each activity.

FACILITY NAME	FACILITY ADDRESS	DATES EMPLOYED

Please answer the following questions. If you answer yes, give specific details (names of organizations, dates, reasons, and outcome) on a Supplement Sheet.

15. Has a licensing agency ever taken adverse or disciplinary action against your license? If yes, attach agency documents filed in the action including all complaints, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements. ☐ Yes ☐ No

16. Have you ever voluntarily surrendered, cancelled, forfeited or failed to renew a license as a result of any of the following: having a complaint filed against you; entering into a consent agreement with respect to your license as a result of a complaint; during an investigation or during disciplinary proceedings? If yes, attach a detailed explanation identifying each occasion, the date and the substance of the allegations. ☐ Yes ☐ No

17. Has a complaint ever been made against you alleging unethical behavior, standard of care issues or unprofessional conduct? If yes, attach a detailed explanation. ☐ Yes ☐ No

18. Has any legal or disciplinary action been filed against you, which relates to your propriety of, or your fitness to practice this profession (including malpractice, etc.)? If yes attach a detailed explanation of each instance including the date of the claim, name and address of party complaining, name and address of forum or court where claim was filed, docket or claim number and the substance of the allegations. ☐ Yes ☐ No

19. Have you ever voluntarily or involuntarily surrendered the privilege to prescribe or dispense any drug, including but not limited to controlled substances, or had such privileges investigated, denied, restricted, suspended, revoked or otherwise modified by any governmental agency, including but not limited to the Drug Enforcement Administration, any state licensing or disciplinary court or other entity? If yes, attach a detailed explanation. ☐ Yes ☐ No

20. Have you ever been expelled from or asked to resign from any professional organization or been censured by a professional organization of which you were a member? If yes, attach a detailed explanation. ☐ Yes ☐ No

21. Do you have criminal charges pending or have ever plead guilty, forfeited bond, or been convicted of a crime (including plea of no contest or deferred prosecution) whether or not an appeal is pending? You may omit: (1) payment of traffic misdemeanor fines and (2) charges or convictions prior to your 16th birthday. If yes, please attach a detailed explanation. ☐ Yes ☐ No

22. Do you have any physical or mental condition(s) which may have or has adversely affected your ability to practice this profession, including but not limited to a contagious or infectious disease involving serious risk to the public? If yes, attach a detailed explanation. ☐ Yes ☐ No

23. Have you used alcohol or any other mood-altering substance in a manner which may have or has adversely affected your ability to practice this profession? If yes, attach a detailed explanation. ☐ Yes ☐ No

24. List all licenses, registrations and certificates which you hold or **ever** have held. Verifications for each license must be sent directly to Montana from each state licensing board.

State	License #	Issue Date	Expiration Date	License Method	Requested State Verification
				☐ Exam ☐ Endorse ☐ Other	☐ Yes ☐ No
				☐ Exam ☐ Endorse ☐ Other	☐ Yes ☐ No
				☐ Exam ☐ Endorse ☐ Other	☐ Yes ☐ No
				☐ Exam ☐ Endorse ☐ Other	☐ Yes ☐ No
				☐ Exam ☐ Endorse ☐ Other	☐ Yes ☐ No

25. **PROFESSIONAL & CHARACTER REFERENCES**

Please type or print names and addresses of three references (at least two must be licensed nutritionists) who have known or associated with you for a minimum of one year. Attached is a reference form (page 7), please submit the form to each of the three individuals listed below and have them mail the reference directly to the Board of Medical Examiners' office on your behalf.

NAME:
ADDRESS:
TELEPHONE:

NAME:
ADDRESS:
TELEPHONE:

NAME:
ADDRESS:
TELEPHONE:

AFFIX PHOTO HERE

PASSPORT SIZE

AFFIDAVIT

I authorize the release of information concerning my education, training, record, character, license history and competence to practice, by anyone who might possess such information, to the Montana Department of Labor and Industry, Healthcare Licensing Bureau.

I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds. I have read and will abide by the current licensure statutes and rules of the State of Montana governing the profession. I will abide by the current laws and rules that govern my practice.

_____ _____
Legal Signature of Applicant Dated

Subscribed and sworn to before me this _____ day of _____, _____at

_____
City/State

_____
Signature of Notary Public

_____
Printed Name of Notary Public

_____
For the State of

My commission expires _____, _____.

VERIFICATION OF LICENSURE

THIS IS NOT AN ENDORSEMENT CERTIFICATION

PLEASE COMPLETE THIS SECTION OF THE FORM AND MAIL TO EACH STATE BOARD IN WHICH YOU ARE NOW OR HAVE EVER BEEN LICENSED TO PRACTICE AS A NUTRITIONIST. YOU MAY COPY THIS FORM AS MANY TIMES AS NEEDED. SOME BOARDS REQUIRE A FEE FOR THIS SERVICE.

STATE BOARD:

I am applying for a license to practice as a Nutritionist in the State of Montana. The Medical Board requires this form to be completed by each state wherein I hold or ever have held a professional/occupational license. This is your authority to release any information in your files, favorable or otherwise, **DIRECTLY** to the **BOARD OF MEDICAL EXAMINERS, P. O. BOX 200513, 301 SOUTH PARK AVENUE, HELENA, MT 59620-0513**. Your early response is appreciated.

_____ Name: _____
(Signature) (Please print)

Address: _____

My License Number is: _____

DO NOT DETACH -- THIS SECTION TO BE COMPLETED BY AN OFFICIAL OF THE STATE BOARD AND RETURNED DIRECTLY TO THE MONTANA STATE BOARD OF MEDICAL EXAMINERS

State of: _____

Full Name of Licensee: _____

License No. _____ Issue Date: _____

License is current? _____ If NO, explain _____

Has license been suspended, revoked, placed on probation or otherwise disciplined? _____

If YES, explain and attach documentation _____

_____

Has licensee ever been requested to appear before your Board? _____

If YES, explain _____

Derogatory information, if any _____

Comments, if any _____

Signed: _____

BOARD SEAL

Title: _____

State Board: _____ Date: _____

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VERIFICATION OF MORAL/PROFESSIONAL CHARACTER

APPLICANT: Complete the upper portion of this form and mail to each character reference you have listed in your application (page 4).

_____ _____
Legal Signature of Applicant Date

(Please Type or Print):
Name of Applicant: _____

Address: _____

This verification sent to: _____

CHARACTER REFERENCE: Please answer the following questions concerning the applicant's moral and professional character. This document is your authorization to release any and all information and opinions you have, favorable or otherwise, directly to the Montana Board of Medical Examiners. Your response will be kept confidential.

Name of reference: _____ Daytime phone: _____

Address: _____

Title/profession/position: _____

How long have you known the applicant? _____ In what capacity? _____

To your knowledge, does this applicant have any habits or practices that would adversely affect his/her professional activities? If your answer is "yes," please explain: _____

Do you consider this applicant worthy of approval to practice as a licensed nutritionist in Montana? _____

Please comment on the applicant's professional character, morals and ethics (attach additional sheet as needed) _____

_____ _____
Signature of Reference Date

The Applicant and the Board thank you for your assistance.